Schedule of Benefits

The Schedule of Benefits is attached to and forms part of your Policy. The benefits shown in this Schedule of Benefits are available for the persons listed in the Policy.

Health Expense Coverage for You and Your Dependents

The Policy spells out the period to which each maximum applies. These benefits apply separately to each covered person. All maximums included in this Policy are combined maximums between **network services and supplies** and **out-of-network services and supplies**, unless stated otherwise. Read the coverage section in your Policy for a complete description of the benefits payable.

If a **hospital** or other health care facility does not separately identify the specific amounts of its **room and board** charges and its other charges, **Aetna** will use the following allocations of these charges for the purposes of the Policy:

Room and board charges:	40%
Other charges:	60%

This allocation may be changed at any time if **Aetna** finds that such action is warranted by reason of a change in factors used in the allocation.

PPO Medical Plan Coverage

Precertification Benefit Reduction

Certain services, such as inpatient stays, must be certified as necessary if full benefits are to be available under the Policy.

The Policy contains complete descriptions of the precertification programs for medical and **prescription drug** benefits. For medical benefits, refer to the *"Understanding Medical Precertification"* section for a list of services and supplies that require precertification. For **prescription drug** benefits, refer to the *"Understanding Pharmacy Precertification"* section.

The Policy lists the services which must be certified and gives you details on how to obtain certification and avoid a **precertification** benefit reduction.

Failure to precertify your **covered benefits** for certain medical services when required will result in a **precertification** benefits reduction as follows:
A $400 penalty will be applied separately to each type of expense.

Precertification and **step therapy** for certain **prescription drugs** is required. If **precertification** is not obtained, the **prescription drug** will not be covered.

The Benefits Payable

After any applicable **deductible,** the plan benefits payable under this Policy in a **calendar year** are paid at the **coinsurance** which applies to the type of **covered benefit** which is incurred. Benefits may vary depending upon whether a **network provider** or **out-of-network provider** is utilized. A copy of a **directory** which lists these health care providers is available on-line at [www.aetna.com/docfind/custom/advplans], or may be requested by calling [Member Services] at the toll-free number on the back of your ID Card.

PPO Medical Plan

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Calendar Year Deductibles:		
Individual Deductible	$3,750	$7,500
Family Deductible	$7,500	$15,000
Important Notes: **Covered benefits** that are subject to these **deductibles** include those charges incurred for medical, vision, and dental benefits under the plan. You have a separate **deductible** that applies for network and out-of-network **covered benefits**. This means that **covered benefits** applied to the **out-of-network deductible** will not be applied to satisfy the **network deductible** and **covered benefits** applied to the **network deductible** will not be applied to satisfy the **out-of-network deductible**. The **calendar year deductible** that applies to **prescription drug** benefits under this plan is found later in this *Schedule of Benefits* under the *Pharmacy Benefit* section. ***All Covered Benefits Are Subject To The Calendar Year Deductibles Unless Otherwise Noted in the Schedule Below.***		

Plan Maximum Out-of-Pocket Limits

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Plan Maximum Out-of-Pocket Limits:		
Individual Maximum Out-of-Pocket Limit	$6,600	Not Applicable
Family Maximum Out-of-Pocket Limit	$13,200	Not Applicable

Covered benefits that are subject to the plan **maximum out-of-pocket limits** include those charges incurred for medical, dental, vision, and **prescription drug** benefits under the plan.

The plan **maximum out-of-pocket limits** include **deductibles, coinsurance** and **copayments**. You have a separate **maximum out-of-pocket limit** for network and out-of-network **covered benefits**. This means that eligible expenses applied to the **out-of-network maximum out-of-pocket limits** will not be applied to satisfy the **network maximum out-of-pocket limits.** Eligible expenses applied to the **network maximum out-of-pocket limits** will not be applied to satisfy the **out-of-network maximum out-of-pocket limits**.

Network: Expenses That Do Not Apply to Your Plan Network Maximum Out-of-Pocket Limit
The following expenses do not apply toward your plan network **maximum out-of-pocket limit(s)**:

- Non-**covered benefits.**

Out-of-Network: Expenses That Do Not Apply to Your Plan Out-of-Network Maximum Out-of-Pocket Limit
The following expenses do not apply toward your plan out-of network **maximum out-of-pocket limit**(s):

- Charges over the **recognized charge**;
- Non-**covered benefits**; and
- Expenses that are not paid or **precertification** benefit reductions because a required **precertification** for the service(s) or supply was not obtained from **Aetna**.

Coinsurance listed in the Schedule below reflects the Plan Coinsurance. This is the amount Aetna pays. You are responsible to pay any deductibles, copayments, and the remaining coinsurance. You are responsible for full payment of any non-covered benefits that you incur.

Important Notes: Refer to the *Expense Provisions* section later in this Schedule of Benefits for more information about copayments, deductibles, coinsurance and maximum out-of-pocket limits.

Benefit maximums for specific covered benefits, including visit, day and dollar maximums are combined maximums between network and out-of-network, unless specifically stated otherwise.

If any expense is covered under one type of covered benefit, it cannot be covered under any other type.

Important Note: Deductibles, coinsurance and copayments shall not apply to any **covered benefit** for any service or supply furnished directly to you by the Indian Health Service, an Indian Tribe, Tribal Organization, Urban Indian Organization, or through referral under contract health services.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Preventive Care		
Routine Physical Exams		
Office Visits	The plan pays 100% per exam No **copayment** or **calendar year deductible** applies.	The plan pays 50% per exam after calendar year **deductible**
Covered Persons up to age 18: Maximum Age & Visit Limits per calendar year	Coverage is limited to 7 exams in the first year of life; 3 exams in the second year of life; 3 exams in the third year of life; 1 exam per year thereafter to age 18.	Coverage is limited to 7 exams in the first year of life; 3 exams in the second year of life; 3 exams in the third year of life; 1 exam per year thereafter to age 18.

Covered Persons ages 18 through age 21: Maximum Visits per calendar year	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents. *For details, contact your **physician** or [Member Services] by [logging onto the Aetna website www.aetna.com, or] calling the toll-free number on the back of your ID card.*	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents. *For details, contact your **physician** or [Member Services] by [logging onto the Aetna website www.aetna.com,] or calling the toll-free number on the back of your ID card.*
Covered Persons age 22 and over: Maximum Visits per calendar year	1 visit	1 visit
Preventive Care Immunizations		
Performed in a facility or physician's office *Subject to any age limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*	The plan pays 100% per visit No **copayment** or **calendar year deductible** applies.	The plan pays 50% per visit after the **calendar year deductible**.
Well Woman Preventive Visits		
Office Visits	The plan pays 100% per visit No **copayment** or **calendar year deductible** applies.	The plan pays 50% per visit after the **calendar year deductible**
Maximum Visits per calendar year	Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.	Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
Screening & Counseling Services		
Office Visits • Obesity and healthy diet counseling • Misuse of alcohol and/or drugs • Use of tobacco products	The plan pays 100% per visit No **copayment** or **calendar year deductible** applies.	The plan pays 50% per visit after the **calendar year deductible**

• Sexually transmitted infection counseling • Genetic risk counseling for breast and ovarian cancer		
Screening & Counseling Services Maximums		
Obesity and Healthy Diet Counseling:		
Maximum visits per calendar year *(This maximum applies only to Covered Persons ages 22 & older.)*	26 visits *(however, of these only 10 visits will be allowed under the Plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)******	26 visits *(however, of these only 10 visits will be allowed under the Plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)******
Note:** ***In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.		
Misuse of Alcohol and/or Drugs:		
Maximum visits per calendar year	5 visits*****	5 visits*****
Note:** ***In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.		
Use of Tobacco Products:		
Maximum visits per calendar year	8 visits*****	8 visits*****
Note:** ***In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.		
Sexually Transmitted Infection Counseling:		
Maximum visits per calendar year	2 visits*	2 visits*
Note:** ***In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.		
Genetic Risk Counseling for Breast and Ovarian Cancer:		
Maximum visits per calendar year	Not subject to any age or frequency limitations	Not subject to any age or frequency limitations
Note:** ***In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.		
Routine Cancer Screenings		
Routine Baseline Mammography (One baseline mammogram for covered females between 35 and 40 years of age)	The plan pays 100% per test No **copayment** or **calendar year deductible** applies.	The plan pays 50% per test after the **calendar year deductible**
Outpatient – All Other Screenings	The plan pays 100% per test No **copayment** or **calendar year deductible** applies.	The plan pays 50% per test after the **calendar year deductible**
Lung Cancer Screening Maximum	1 screening every 12 months*	1 screening every 12 months*

*Important Note: Lung cancer screenings in excess of the maximum as shown above are covered under the *Outpatient Diagnostic and Preoperative Testing* section of your *Schedule of Benefits.*		
All Other Screening Maximums	Subject to any age; family history; and frequency guidelines as set forth in the most current: • evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • the comprehensive guidelines supported by the Health Resources and Services Administration. *For details, contact your **physician** or [Member Services] by [logging onto the Aetna website www.aetna.com or] calling the toll-free number on the back of your ID card.*	Subject to any age; family history; and frequency guidelines as set forth in the most current: • evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • the comprehensive guidelines supported by the Health Resources and Services Administration. *For details, contact your **physician** or [Member Services] by [logging onto the Aetna website www.aetna.com or] calling the toll-free number on the back of your ID card.*
Prenatal Care		
Office Visits	The plan pays 100% per visit No **copayment** or **calendar year deductible** applies.	The plan pays 50% per visit after the **calendar year deductible**
Important Note: Refer to the *Physician Services*, *Diagnostic and Preoperative Testing* and *Pregnancy Expenses* sections of this *Schedule of Benefits* for more information on coverage levels for pregnancy expenses under this Plan, including other prenatal care, delivery and postnatal care services.		
Comprehensive Lactation Support and Counseling Services		
Lactation Counseling Services - *Facility or Office Visits*	The plan pays 100% per visit No **copayment** or **calendar year deductible** applies.	The plan pays 50% per visit after the **calendar year deductible**
Lactation Counseling Services Maximum Visits per calendar year either in a group or individual setting	6 visits*	6 visits*
***Important Note:** Visits in excess of the Lactation Counseling Services Maximum Visits, are covered under the *Physician Services* office visit section of the *Schedule of Benefits*.		
Breast Feeding Durable Medical Equipment	The plan pays 100% per item No **copayment** or **calendar year deductible** applies.	The plan pays 50% per item after the **calendar year deductible**

Important Note: Refer to the *Comprehensive Lactation Support and Counseling Services* section of the Policy for limitations on breast pumps and supplies.		
Family Planning Services - Female Contraceptives		
Female Contraceptive Counseling Services		
Office Visits	The plan pays 100% per visit No **copayment** or **calendar year deductible** applies.	The plan pays 50% per visit after the **calendar year deductible**
Contraceptive devices or generic prescription drugs provided by a physician during an office visit for female contraceptive counseling	The plan pays 100% per item No **copayment** or **calendar year deductible** applies.	The plan pays 50% per item after the **calendar year deductible**
Female Contraceptive Counseling Services Maximum Visits per calendar year either in a group or individual setting	2 visits*	2 visits*
***Important Note:** Visits in excess of the Female Contraceptive Counseling Services Maximum Visits above, are covered under the *Physician Services* office visit section of the *Schedule of Benefits.*		
Important note: See *Outpatient prescription contraceptive drugs and devices* section for more information on other prescription drug coverage under this plan.		
Female Voluntary Sterilization		
Inpatient	The plan pays 100% per admission No **copayment** or **calendar year deductible** applies.	The plan pays 50% per admission after the **calendar year deductible**
Outpatient	The plan pays 100% per visit/surgical procedure No **copayment** or **calendar year deductible** applies.	The plan pays 50% per visit/surgical procedure after the **calendar year deductible**
Additional Covered Medical Expenses		
Family Planning Services – Other		
-Voluntary Sterilization for Males	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Hormone Replacement Therapy Services		
	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Vision Care Benefits		
Pediatric Routine Vision Exams (including refraction) *Coverage is limited to covered persons through age 18.*		
Performed by a legally qualified ophthalmologist or optometrist	The plan pays 100% per exam No **calendar year deductible** applies	The plan pays 50% per exam after the **calendar year deductible**
Maximum Visits per calendar year	1 visit	1 visit
Pediatric Vision Care Services and Supplies *Coverage is limited to covered persons through age 18.*		
- Eyeglass Frames Prescription Lenses or Prescription Contact Lenses *	The plan pays 100% per item No **calendar year deductible** applies	The plan pays 50% per item after the **calendar year deductible**
Eyeglass Frames Maximum per **calendar year**	One set of eyeglass frames	One set of eyeglass frames
Prescription Lenses Maximum per **calendar year**	One pair of **prescription** lenses	One pair of **prescription** lenses
Prescription Contact Lenses Maximum per **calendar year** (*includes Non-Conventional **Prescription** Contact Lenses and Aphakic Lenses Prescribed After Cataract Surgery*)	Daily Disposables: Up to 3 month supply Extended Wear Disposable: Up to 6 month supply Non-Disposable Lenses: One set	Daily Disposables: Up to 3 month supply Extended Wear Disposable: Up to 6 month supply Non-Disposable Lenses: One set
Low Vision Exam Maximum	No less than 1 exam every 5 years	No less than 1 exam every 5 years

***Important Note:** Refer to the *Vision Care Benefit* in the Policy for the explanation of these vision care supplies**.**

As to coverage for **prescription** lenses in a calendar year, this benefit will cover either **prescription** lenses for eyeglass frames or **prescription** contact lenses, but not both. **Exception:** When an aphakic lens is prescribed after cataract surgery, we will cover eyeglass frames in addition to the lens.

Coverage does not include the office visit for the fitting of **prescription** contact lenses.

Adult Vision Care Services and Supplies *Coverage is limited to covered persons age 19 and older.*		
- Non-Conventional Prescription Contact Lenses and Aphakic Lenses Prescribed After Cataract Surgery	Payable on the same basis as a prosthetic expense. Refer to the *Prosthetic Devices* section of this *Schedule of Benefits*.	Payable on the same basis as a prosthetic expense. Refer to the *Prosthetic Devices* section of this *Schedule of Benefits*.
Physician Services		
PCP-Physician Office Visits *(non-surgical)*	$10 **copayment** per visit, then the plan pays 100% No **calendar year deductible** applies	The plan pays 50% per visit after the **calendar year deductible**
Complex imaging services performed during a PCP-Physician Office Visit.	$250 **copayment** per procedure after **calendar year deductible** then the plan pays 70%	The plan pays 50% per procedure after the **calendar year deductible**
PCP-Physician Office Visits-Surgery	$10 **copayment** per visit, then the plan pays 100% No **calendar year deductible** applies	The plan pays 50% per visit after the **calendar year deductible**
PCP-Physician Services for Inpatient Facility and Hospital Visits	The plan pays 70% per visit after **calendar year deductible**	The plan pays 50% per visit after the **calendar year deductible**
PCP-Administration of Anesthesia	The plan pays 70% per procedure after **calendar year deductible**	The plan pays 50% per procedure after the **calendar year deductible**
PCP Administration of Allergy Injections	$10 **copayment** per visit, then the plan pays 100% No **calendar year deductible** applies	The plan pays 50% per visit after the **calendar year deductible**
PCP Office Allergy Injections *(applies when you do not see the **physician**)*	The plan pays 70% per procedure after **calendar year deductible**	The plan pays 50% per visit after the **calendar year deductible**
PCP-Physician -Postnatal and Delivery Care	One-time $250 **copayment** then the plan pays 100% No **calendar year deductible** applies.	The plan pays 50% per visit after the **calendar year deductible**
Specialist Physician Services		
Specialist-Office Visits (Non-Surgical) *All Specialists except those specifically listed in this schedule.*	$75 **copayment** per visit, then the plan pays 100% No **calendar year deductible** applies	The plan pays 50% per visit after the **calendar year deductible**

Specialist-Physician Office Visits (Surgery)	The plan pays 70% per visit after the **calendar year deductible**	The plan pays 50% per visit after the **calendar year deductible**
Complex imaging services Performed during a Specialist-Physician Office Visit.	$250 **copayment** per procedure after **calendar year deductible** then the plan pays 70%	The plan pays 50% per procedure after the **calendar year deductible**
Specialist-Physician Services for Inpatient Facility and Hospital Visits	The plan pays 70% per visit after **calendar year deductible**	The plan pays 50% per visit after the **calendar year deductible**
Specialist-Administration of Anesthesia	The plan pays 70% per procedure after **calendar year deductible**	The plan pays 50% per procedure after the **calendar year deductible**
Specialist-Administration of Allergy Injections	$75 **copayment** per visit, then the plan pays 100% No **calendar year deductible** applies	The plan pays 50% per visit after the **calendar year deductible**
Specialist Physician Allergy Testing *(applies whether you see or do not see the **physician**)*	$75 **copayment** per visit, then the plan pays 100% No **calendar year deductible** applies	The plan pays 50% per visit after the **calendar year deductible**
Specialist Physician Allergy Treatment *(applies whether you see or do not see the **physician**)*	$75 **copayment** per visit, then the plan pays 100% No **calendar year deductible** applies	The plan pays 50% per visit after the **calendar year deductible**
Specialist Office Allergy Injections *(applies when you do not see the **physician**)*	The plan pays 70% per visit after **calendar year deductible**	The plan pays 50% per visit after the **calendar year deductible**
Specialist-Physician -Postnatal and Delivery Care	One-time $250 **copayment** then the plan pays 100% No **calendar year deductible** applies.	The plan pays 50% per visit after the **calendar year deductible**
Alternatives to Physician Office Visits		
Walk-In Clinic Visits (Non-Emergency)		
Preventive Care Services*		
Immunizations	The plan pays 100% per visit No **copayment** or **calendar year deductible** applies.	The plan pays 50% per visit after the **calendar year deductible**
Individual Screening and Counseling Services for Tobacco Use	The plan pays 100% per visit No **copayment** or **calendar year**	The plan pays 50% per visit after the **calendar year deductible**

	deductible applies.	
Maximum Benefit per visit - *Individual Screening and Counseling Services for Tobacco Use*	*Refer to the Preventive Care Benefits section earlier in this Schedule of Benefits for maximums that may apply to these types of services.*	*Refer to the Preventive Care Benefits section earlier in this Schedule of Benefits for maximums that may apply to these types of services.*
Individual Screening and Counseling Services for Obesity and Healthy Diet	The plan pays 100% per visit No **copayment** or **calendar year deductible** applies.	The plan pays 50% per visit after the **calendar year deductible**
Maximum Benefit per visit - *Individual Screening and Counseling Services for Obesity and Healthy Diet*	*Refer to the Preventive Care Benefits section earlier in this Schedule of Benefits for maximums that may apply to these types of services.*	*Refer to the Preventive Care Benefits section earlier in this Schedule of Benefits for maximums that may apply to these types of services.*
***Important Note:** Not all preventive care services are available at all **Walk-In Clinics**. The types of services offered will vary by the provider and location of the clinic. These services may also be obtained from a **physician**.		
All Other Services		
	\$10 **copayment** per visit, then the plan pays 100% No **calendar year deductible** applies.	The plan pays 50% per visit after the **calendar year deductible**
E-Visit Consultations		
- **Specialist E-Visit Consultation**	\$30 **copayment** per visit, then the plan pays 100% No **calendar year deductible** applies	Not Covered
- **Non-Specialist E-Visit Consultation**	\$10 **copayment** per visit, then the plan pays 100% No **calendar year deductible** applies	Not Covered
Teladoc Telemedicine Consultations		
Teladoc Telemedicine Consultation	\$10 **copayment** per visit, then the plan pays 100% No **calendar year deductible** applies	The plan pays 50% per visit after the **calendar year deductible**

Hospital Facility Expenses		
Inpatient Services (including maternity)	\$500 **copayment** per admission after **calendar year deductible** then the plan pays 70%	\$1,000 **deductible** per admission after **calendar year deductible** then the plan pays 50%

Outpatient Services (including maternity)	The plan pays 70% per visit after the **calendar year deductible**	The plan pays 50% per visit after the **calendar year deductible**
Emergency Medical Conditions		
Hospital Emergency Facility and Physician	$500 **copayment** per visit after **calendar year deductible** then the plan pays 100%	Paid the same as In-Network ***See the ***Important Note*** below.*
***Important Note:** Please note that as **out-of-network providers** are not **network providers** and do not have a contract with **Aetna**, the provider may not accept payment of your cost share (your **deductible** and **coinsurance)**, as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this Plan. If the Emergency Room Facility or **physician** bills you for an amount above your cost share, you are not responsible for paying that amount. Please send us the bill at the address listed your member ID card and we will resolve any payment dispute with the provider over that amount. Make sure your member ID number is on the bill.		
Non-Emergency Care in a Hospital Emergency Room	Not Covered	
Important Note: A separate **hospital** emergency room **copayment** or **deductible** applies for each visit to an emergency room for emergency care. If you are admitted to a **hospital** as an inpatient immediately following a visit to an emergency room, your **copayment** or **deductible** is waived. **Covered benefits** that are applied to the emergency room **copayment** or **deductible** cannot be applied to any other **copayment** or **deductible** under your plan. Likewise, **covered benefits** that are applied to any of your plan's other **copayments** or **deductible** cannot be applied to the emergency room **copayment** or **deductible**.		
Urgent Care Conditions		
Urgent Care Facility *(Non-hospital free standing facility)*	$75 **copayment** per visit then the plan pays 100% No **calendar year deductible** applies	The plan pays 50% per visit after **calendar year deductible**
Urgent Care Facility *(Other than a non-hospital free standing facility*	*Refer to the Emergency Medical Conditions and Physician Services sections above*	*Refer to the Emergency Medical Conditions and Physician Services sections above*
Non-Urgent Use of Urgent Care Facility *(At an Emergency Room or a non-hospital free standing facility)*	Not Covered	
Important Note: A separate **urgent care copayment** or **deductible** applies for each visit to an **urgent care provider** for **urgent care**. **Covered benefits** that are applied to the **urgent care copayment** or **deductible** cannot be applied to any other **copayment** or **deductible** under your plan. Likewise, **covered benefits** that are applied to your plan's other **copayments** or **deductible** cannot be applied to the **urgent care copayment** or **deductible**		

Pregnancy Expenses		
Includes coverage for complications of pregnancy	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Birthing Center Facility and Physician Expenses		
Facility Services	$500 **copayment** per admission after **calendar year deductible** then the plan pays 70%	$1,000 **deductible** per admission after **calendar year deductible** then the plan pays 50%
Physician Services	The plan pays 70% per visit after the **calendar year deductible**	The plan pays 50% per visit after the **calendar year deductible**
Alternatives to Hospital Stays		
Outpatient Surgery and Physician Surgical Services		
Facility Services	$250 **copayment** per procedure after **calendar year deductible**, then the plan pays 70%	The plan pays 50% per procedure after **calendar year deductible**
Physician Services	The plan pays 70% per visit/ after **calendar year deductible**	The plan pays 50% per visit after **calendar year deductible**
Home Health Care		
Outpatient Services	The plan pays 70% per visit after **calendar year deductible**	The plan pays 50% per visit after **calendar year deductible**
Maximum Visits per **calendar year**	30	
Skilled Nursing Facility		
Facility Services	The plan pays 70% per admission after **calendar year deductible**	$1,000 **deductible** per admission after **calendar year deductible** then the plan pays 50%
Maximum Days per **calendar year**	100	
Physician Services	The plan pays 70% per admission after **calendar year deductible**	The plan pays 50% per admission after **calendar year deductible**
Hospice Care		
Facility Services	The plan pays 70% per admission after **calendar year deductible**	$1,000 **deductible** per admission after **calendar year deductible** then the plan pays 50%
Physician Services	The plan pays 70% per visit after **calendar year deductible**	The plan pays 50% visit after **calendar year deductible**

Outpatient Visits	The plan pays 70% per visit after **calendar year deductible**	The plan pays 50% per visit after **calendar year deductible**

Other Covered Health Care Expenses		
Acupuncture		
Anesthesia only	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Ambulance		
Ground Ambulance	The plan pays 70% per trip after **calendar year deductible**	The plan pays 70% per trip after **calendar year deductible**
Air or Water Ambulance	The plan pays 70% per trip after **calendar year deductible**	The plan pays 70% per trip after **calendar year deductible**
Non-Emergency Ambulance	The plan pays 70% per trip after **calendar year deductible**	The plan pays 50% per trip after **calendar year deductible**
Diagnostic and Preoperative Testing		
Diagnostic Complex Imaging Services		
Performed at a Hospital Outpatient Facility	$250 **copayment** per procedure after **calendar year deductible** then the plan pays 70%	The plan pays 50% per procedure after **calendar year deductible**
Performed at Freestanding Facility	$250 **copayment** per procedure after **calendar year deductible** then the plan pays 70%	The plan pays 50% per procedure after **calendar year deductible**
Outpatient Prenatal Ultrasound		
Performed at a Hospital Outpatient Facility	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Performed at a facility other than a Hospital Outpatient Facility	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Outpatient Diagnostic Lab Work		
Performed at a Hospital Outpatient Facility	$25 **copayment** per visit, then the plan pays 100% No **copayment** or **calendar year deductible** applies.	The plan pays 50% per procedure after **calendar year deductible**
Performed at a facility other than a Hospital Outpatient Facility	$25 **copayment** per visit, then the plan pays 100% No **copayment** or **calendar year deductible** applies.	The plan pays 50% per procedure after **calendar year deductible**
Outpatient Diagnostic Radiological Services		
Performed at a Hospital Outpatient Facility	The plan pays 70% per procedure after **calendar year deductible**	The plan pays 50% per procedure after **calendar year deductible**
Performed at a Facility other than a Hospital Outpatient Facility	The plan pays 70% per procedure after **calendar year deductible**	The plan pays 50% per procedure after **calendar year deductible**
Outpatient Preoperative Testing		
Performed at a Hospital Outpatient Facility	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Performed at a facility other than a Hospital Outpatient Facility	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Durable Medical and Surgical Equipment (DME)		
Durable Medical and Surgical Equipment	The plan pays 50% per item after the **calendar year deductible**	The plan pays 50% per item after the **calendar year deductible**
Prosthetic Devices		
Hearing Aids	The plan pays 50% per item after the **calendar year deductible**	The plan pays 50% per item after the **calendar year deductible**
Hearing Aids Maximum	One hearing aid per ear every 48 month consecutive period.	One hearing aid per ear every 48 month consecutive period.
All Other **Prosthetic Devices**	The plan pays 50% per item after the **calendar year deductible**	The plan pays 50% per item after the **calendar year deductible**

Non-Prescription Enteral Formula		
	The plan pays 50% per supply after the **calendar year deductible**	The plan pays 50% per supply after the **calendar year deductible**
Treatment of Temporomandibular Joint Dysfunction		
	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Short Term Cardiac and Pulmonary Rehabilitation Therapies		
Cardiac Rehabilitation	The plan pays 70% per visit after **calendar year deductible**	The plan pays 50% per visit after **calendar year deductible**
Pulmonary Rehabilitation	The plan pays 70% per visit after **calendar year deductible**	The plan pays 50% per visit after **calendar year deductible**
Short Term Rehabilitation Therapies		
Outpatient Physical, Occupational, Speech and Cognitive Rehabilitation Therapies (combined)	The plan pays 70% per visit after **calendar year deductible**	The plan pays 50% per visit after **calendar year deductible**
Maximum Visits per **calendar year**	60 visits per calendar year	
Spinal Manipulation	The plan pays 70% per visit after **calendar year deductible**	The plan pays 50% per visit after **calendar year deductible**
Maximum Visits per **calendar year**	12 visits per calendar year	
Habilitation Therapy Services		
Outpatient Physical, Occupational, Speech and Cognitive Habilitation Therapies (combined)	The plan pays 70% per visit after the **calendar year deductible**	The plan pays 50% per visit after the **calendar year deductible**
Maximum Visits per **calendar year**	60 visits per calendar year	
Autism Spectrum Disorders		
Autism Spectrum Disorders	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Maximum Benefit for Applied Behavioral Analysis per **calendar year** Once the benefit maximum has been reached, coverage for Applied Behavioral Analysis will cease. All other coverage for diagnosis and all other treatment of Autism Spectrum Disorders will continue to be provided on the same basis as for any other medical service or prescription drug coverage under this Policy	550 hours per **calendar year**

Specialized Care		
Reconstructive or Cosmetic Surgery and Supplies		
Coverage is provided only to the extent as described in the Booklet-Certificate	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Reconstructive Breast Surgery		
	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Treatment of Obesity		
Bariatric Surgery	The plan pays 50% per surgical procedure after **calendar year deductible**	$1,000 **deductible** per surgical procedure after **calendar year deductible** then the plan pays 50%
Maximum Benefit	1 procedure per lifetime	1 procedure per lifetime
Experimental or Investigational Treatment		
	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Clinical Trials Expenses		
Clinical Trials	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Outpatient Therapies		
Chemotherapy Benefits	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Radiation Therapy Benefits	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Infusion Therapy Benefits *- Performed in a Physician's Office or Home Care*	The plan pays 70% per visit after the **calendar year deductible**	The plan pays 50% per visit after the **calendar year deductible**
- Performed in a Hospital Outpatient Department or Non-Hospital Outpatient Facility	The plan pays 70% per visit after **calendar year deductible**	The plan pays 50% per visit after **calendar year deductible**
Diabetes Benefit		
(Services, Supplies, Equipment and Training)	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Basic Infertility Expenses		
Coverage is only for the diagnosis and treatment of the underlying medical condition causing the infertility.	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Comprehensive Infertility Expenses		
	The plan pays 50% per procedure after **calendar year deductible**	The plan pays 50% per procedure after **calendar year deductible**
Artificial Insemination Maximum Benefit per lifetime	6 courses of treatment attempts	6 courses of treatment attempts
Ovulation Induction Maximum Benefit per lifetime	6 courses of treatment attempts	6 courses of treatment attempts

PLAN FEATURES	NETWORK IOE Provider/Facility	NETWORK Non-IOE Provider/Facility	OUT-OF-NETWORK
Transplant Services			
Your coverage will be considered out-of-network if it is not provided at an **IOE** facility.			
Transplant Facility Expenses	$500 **copayment** per admission, then the plan pays 70% after the **calendar year deductible**	$1,000 **deductible** per admission after **calendar year deductible** then the plan pays 50%	$1,000 **deductible** per admission after **calendar year deductible** then the plan pays 50%
Transplant Physician Services (including office visits)	The plan pays 70% per visit after **calendar year deductible**	The plan pays 50% per visit after **calendar year deductible**	The plan pays 50% per visit after **calendar year deductible**
Transplant Travel and Lodging Expenses			
Maximum Benefit payable for **IOE** Travel and Lodging Expenses for any one transplant, including tandem transplants	$10,000	Not Covered	Not Covered
Maximum Benefit payable for Lodging Expenses per **IOE** patient	$200 per day	Not Covered	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)		
Only covered benefits that are medical in nature	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Treatment of Mental Disorders		
Inpatient Hospital Expenses		
Facility Services	$500 **copayment** per admission after **calendar year deductible** then the plan pays 70%	$1000 **deductible** per admission after **calendar year deductible** then the plan pays 50%
Physician Services	The plan pays 70% per visit after the **calendar year deductible**	The plan pays 50% per visit after the **calendar year deductible**

Outpatient Hospital Expenses		
Facility Services	The plan pays 70% per visit after the **calendar year deductible**	The plan pays 50% per visit after the **calendar year deductible**
Physician Services	The plan pays 70% per visit after the **calendar year deductible**	The plan pays 50% per visit after the **calendar year deductible**
Outpatient Expenses		
Outpatient **mental disorder** visits to a **physician** or **behavioral health provider** **Partial hospitalization treatment** (at least 4 hours, but less than 24 hours per day of clinical treatment) **Intensive Outpatient Program** (at least 2 hours per day and at least 6 hours per week of clinical treatment) Coverage is provided under the same terms, conditions as any other **illness**.	$75 **copayment** per visit then the plan pays 100% No **calendar year** deductible applies	The plan pays 50% per visit after the **calendar year deductible**
Inpatient Residential Treatment Facility Expenses		
Facility Services	$500 **copayment** per admission after **calendar year deductible** then the plan pays 70%	$1,000 **deductible** per admission after **calendar year deductible** then the plan pays 50%
Physician Services	The plan pays 70% per visit after the **calendar year deductible**	The plan pays 50% per visit after the **calendar year deductible**

Treatment of Substance Abuse		
Inpatient Hospital Expenses		
Facility Services	$500 **copayment** per admission after **calendar year deductible** then the plan pays 70%	$1,000 **deductible** per admission after **calendar year deductible** then the plan pays 50%
Physician Services	The plan pays 70% per visit after the **calendar year deductible**	The plan pays 50% per visit after the **calendar year deductible**

Outpatient Hospital Expenses		
Facility Services	The plan pays 70% per visit after the **calendar year deductible**	The plan pays 50% per visit after the **calendar year deductible**
Physician Services	The plan pays 70% per visit after the **calendar year deductible**	The plan pays 50% per visit after the **calendar year deductible**
Outpatient Expenses		
Outpatient **substance abuse** visits to a **physician** or **behavioral health provider** **Partial hospitalization treatment** (at least 4 hours, but less than 24 hours per day of clinical treatment) **Intensive Outpatient Program** (at least 2 hours per day and at least 6 hours per week of clinical treatment) Coverage is provided under the same terms, conditions as any other **illness**.	$75 **copayment** per visit then the plan pays 100% No **calendar year** deductible applies	The plan pays 50% per visit after the **calendar year deductible**
Inpatient Residential Treatment Facility Expenses		
Facility Services	$500 **copayment** per admission after **calendar year deductible** then the plan pays 70%	$1,000 **deductible** per admission after **calendar year deductible** then the plan pays 50%
Physician Services	The plan pays 70% per visit after the **calendar year deductible**	The plan pays 50% per visit after the **calendar year deductible**

All Other Covered Expenses		
Covered benefits not specifically mentioned above.	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Pediatric Dental Benefit

Coverage is limited to covered persons through age 18

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Type A Expenses	The plan pays 100% No **calendar year deductible** applies	The plan pays 70% No **calendar year deductible** applies
Type B Expenses	The plan pays 70% after the **calendar year deductible**	The plan pays 50% after the **calendar year deductible**
Type C Expenses	The plan pays 50% after the **calendar year deductible**	The plan pays 50% after the **calendar year deductible**
Orthodontic Expenses	The plan pays 50% after the **calendar year deductible**	The plan pays 50% after the **calendar year deductible**

Pharmacy Benefit

PLAN FEATURES		
Prescription Drug Calendar Year Deductibles **(**A separate **calendar year deductible** applies to **prescription drugs**.)		
Important Reminder: **All Prescription Drug Covered benefits Are Subject To The Prescription Drug Calendar Year Deductibles Unless Otherwise Noted in the Schedule Below.**		
PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Prescription Drug Deductible:		
Per Person Deductible	$400	$800

Important Note

Refer to *Your Pharmacy Benefit* and to *What the Pharmacy Benefit Covers* sections in the Policy for details about your outpatient **prescription drug** coverage.

- The *Schedule of Benefits* details your cost sharing.
- *You may pay less* for **prescriptions** if you:
  - Use **generic prescription drugs** rather than **brand name prescription drugs**;
  - Obtain **prescription drugs** from **network pharmacies** rather than **out-of-network pharmacies**;
  - Use **prescription drugs** that are on the **preferred drug guide (formulary)**;
  - Obtain injectable, **self-injectable drugs**, or **specialty care prescription drugs** from a **specialty network pharmacy** or **network pharmacies**;
  - Use a **mail order pharmacy** that is a **network pharmacy** after your initial refill.
- **Precertificatio**n and **step therapy** for certain **prescription drugs** is required. If **precertification** is not obtained, the **prescription drug** will not be covered.

Female Contraceptives - Copayment and Deductible Waiver

Waiver for Prescription Drug Contraceptives

The per **prescription copayment** and any applicable **prescription drug calendar year deductible** will not apply to contraceptive methods that are:

- Dispensed by a **network pharmacy**.
- Female contraceptives that are **generic prescription drugs** and are shown on the **preferred drug list (formulary)**.
- Female contraceptives that are generic emergency contraceptives and are shown on the **preferred drug list (formulary)**.
- Female contraceptive devices (both brand name and generic).
- FDA-approved female generic and brand-name over-the-counter (OTC) contraceptives when filled at the **pharmacy** with a **prescription**.

This means that such contraceptive methods will be paid at 100%.

The **per prescription copayment** and any applicable **prescription drug calendar year deductible** will continue to apply to contraceptive methods that are:

- **Preferred and Non-Preferred Brand-Name Prescription Drugs**; and
- FDA-approved female brand-name emergency contraceptives,

that have a generic equivalent or generic alternative available within the same **therapeutic drug class** unless a covered person is granted a medical exception.

Deductible and Copayment/Coinsurance Waiver for Tobacco Cessation Prescription and Over-the-Counter Drugs

The **calendar year deductible** and the per **prescription copayment/coinsurance** will not apply to the first two 90-day treatment regimens for tobacco cessation **prescription drugs** and OTC drugs when obtained at a retail **network pharmacy**. This means that such **prescription drugs** and OTC drugs will be paid at 100%. Your **calendar year deductible** and any **prescription copayment/coinsurance** will apply after those two regimens have been exhausted.

Waiver for Risk-Reducing Breast Cancer Prescription Drugs

The per **prescription copay/deductible** and **prescription drug deductible** will not apply to risk-reducing breast cancer **preferred generic prescription drugs** when obtained at a **network pharmacy**. This means that such **prescription drugs** will be paid at 100%.

All covered benefits are subject to the prescription drug calendar year deductibles unless otherwise noted in the schedule below.

PHARMACY BENEFIT	NETWORK	OUT-OF-NETWORK
PER PRESCRIPTION COPAYMENTS/DEDUCTIBLES		
Preventive Care Drugs and Supplements		
Preventive care drugs and supplements filled at a **pharmacy** For each 30 day supply	The plan pays 100% per **prescription** or refill No **copayment** or **prescription drug calendar year deductible** applies.	The plan pays 50% per **prescription** or refill after the **prescription drug calendar year deductible**
Maximums:	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by logging onto your Aetna Navigator® secure member website at www.Aetna.com or calling the number on the back of your ID card.	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by logging onto your Aetna Navigator® secure member website at www.Aetna.com or calling the number on the back of your ID card.
Important note: **See *Outpatient prescription contraceptive drugs and devices and Preventive care drugs and supplements* section for more information on other prescription drug coverage under this plan.**		
If you or your prescriber requests a covered brand-name prescription drug when a covered generic prescription drug equivalent is available, you will be responsible for the cost difference between the generic prescription drug and the brand-name prescription drug, plus the cost sharing that applies to brand-name prescription drugs.		

Tobacco Cessation Prescription and Over-the-Counter Drugs		
Tobacco cessation **prescription drugs** and OTC drugs filled at a **pharmacy** For each 30 day supply Maximums: Coverage is permitted for two 90-day treatment regimens only. Any additional treatment regimens will be subject to the cost sharing in your schedule of benefits below. Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the	The plan pays 100% per **prescription** or refill No **copayment** or **calendar year deductible** applies.	The plan pays 50% per **prescription** or refill after the **calendar year deductible**

recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered tobacco cessation **prescription drugs** and OTC drugs, contact [Member Services] by [logging onto your Aetna Navigator® secure member website at www.aetna.com or] calling the number on the back of your ID card.]		

PHARMACY BENEFIT	**NETWORK**		**OUT-OF-NETWORK**
PER PRESCRIPTION COPAYMENTS/DEDUCTIBLES			
	Costco Pharmacy	**Non-Costco Pharmacy**	
Tier 1A -- Value Drugs			
For each 30 day supply filled at a retail **pharmacy**	$3 **copayment** per supply No **prescription drug calendar year deductible** applies.	$20 **copayment** per supply No **prescription drug calendar year deductible** applies.	The plan pays 50% per **prescription** or refill after the **prescription drug calendar year deductible**
For all fills of at least 31 days but no more than a 90 day supply filled at a **mail order pharmacy**	$6 **copayment** per supply No **prescription drug calendar year deductible** applies.	$6 **copayment** per supply No **prescription drug calendar year deductible** applies.	Not Covered

Tier 1 -- Preferred Generic Prescription Drugs			
For each 30 day supply filled at a retail **pharmacy**	$5 **copayment** per **prescription** or refill, then the plan pays 100% No **prescription drug calendar year deductible** applies.	$20 **copayment** per **prescription** or refill, then the plan pays 100% No **prescription drug calendar year deductible** applies.	The plan pays 50% per **prescription** or refill after the **prescription drug calendar year deductible**
For all fills of at least 31 days but no more than a 90 day supply filled at a **mail order pharmacy**	$10 **copayment** per **prescription** or refill, then the plan pays 100% No **prescription drug calendar year deductible** applies.	$10 **copayment** per **prescription** or refill, then the plan pays 100% No **prescription drug calendar year deductible** applies.	Not Covered
Tier 2 -- Preferred Brand-Name Prescription Drugs			
For each 30 day supply filled at a retail **pharmacy**	After the **prescription drug calendar year deductible** has been satisfied, $40 **copayment** per **prescription** or refill	After the **prescription drug calendar year deductible** has been satisfied, $55 **copayment** per **prescription** or refill	The plan pays 50% per **prescription** or refill after the **prescription drug calendar year deductible**
For all fills of at least 31 days but no more than a 90 day supply filled at a **mail order pharmacy**	After the **prescription drug calendar year deductible** has been satisfied, $100 **copayment** per **prescription** or refill	After the **prescription drug calendar year deductible** has been satisfied, $100 **copayment** per **prescription** or refill	Not Covered
Tier 3 –Non-Preferred Generic and Brand Name Prescription Drugs			
For each 30 day supply filled at a retail **pharmacy**	After the **prescription drug calendar year deductible** has been satisfied, $65 **copayment** per **prescription** or refill	After the **prescription drug calendar year deductible** has been satisfied, $85 **copayment** per **prescription** or refill	The plan pays 50% per **prescription** after the **prescription drug calendar year deductible**
For all fills of at least 31 days but no more than a 90 day supply filled at a **mail order pharmacy**	After the **prescription drug calendar year deductible** has been satisfied, $195 **copayment** per **prescription** or refill	After the **prescription drug calendar year deductible** has been satisfied, $195 **copayment** per **prescription** or refill	Not Covered

Tier 4 --Preferred Specialty Care Prescription Drugs			
For each: - Initial 30 day supply at a retail **pharmacy** or **specialty care network pharmacy**; and - 30 day refill at a **specialty network pharmacy**	The plan pays 60% per **prescription** or refill after the **prescription drug calendar year deductible**		The plan pays 50% per **prescription** after the **prescription drug calendar year deductible**
Tier 5 --Non-Preferred Specialty Care Prescription Drugs			
For each: - Initial 30 day supply at a retail **pharmacy** or **specialty care network pharmacy**; and - 30 day refill at a **specialty network pharmacy**	The plan pays 50% per **prescription** or refill after the **prescription drug calendar year deductible**		The plan pays 50% per **prescription** after the **prescription drug calendar year deductible**
Orally Administered Chemotherapy Prescriptions Drugs			
For each 30 day supply filled at a retail or **specialty care pharmacy**	No **prescription drug calendar year deductible** applies to orally administered chemotherapy **prescription drugs** and the covered person will not pay more than $100 per **prescription**.		No **prescription drug calendar year deductible** applies to orally administered chemotherapy **prescription drugs** and the covered person will not pay more than $100 per **prescription**.
Diabetic Prescription Drugs, Supplies and Insulin			
For each 30 day supply filled at a retail **pharmacy**	Paid according to the tier of drug per the *Schedule of Benefits*, above.	Paid according to the tier of drug per the *Schedule of Benefits*, above.	Paid according to the tier of drug per the *Schedule of Benefits*, above.
For all fills of at least 30 days but no more than a 90 day supply filled at a **mail order pharmacy**	Paid according to the tier of drug per the *Schedule of Benefits*, above.	Paid according to the tier of drug per the *Schedule of Benefits*, above.	Not Covered
Split Fill Dispensing			
Split fill dispensing allows 50% of the 30-day supply to be filled at a retail pharmacy. You will pay a prorated amount of your cost share based on the supply.			Not Covered

Expense Provisions

The following provisions apply to your health expense plan.

This section describes cost sharing features, benefit maximums and other important provisions that apply to your plan. The specific cost sharing features and the applicable dollar amounts or benefit percentages are contained in the health expense sections appearing earlier in this *Schedule of Benefits*.

Deductible Provisions

Calendar Year Deductible
This is the amount **covered benefits** you must incur in a **calendar year** before benefits are paid. The **calendar year deductible** applies separately to you and each of your covered dependents. After **covered benefits** reach the **calendar year deductible,** this plan will begin to pay benefits for **covered benefits** for the rest of the **calendar year.**

Network Calendar Year Deductible
This is the amount of **covered benefits** for **network services and supplies** you must incur in a **calendar year** before benefits are paid. The network **calendar year deductible** applies separately to you and each of your covered dependents. After **covered benefits** reach the network **calendar year deductible,** the plan will begin to pay benefits for **covered benefits** for **network services and supplies** for the rest of the **calendar year**. **Covered benefits** applied to the out-of-network **calendar year deductible** will not be applied to satisfy this network **calendar year deductible**.

Out-of-Network Calendar Year Deductible
This is the amount of **covered benefits** for **out-of-network services and supplies** you must incur in a **calendar year** before benefits are paid. The out-of-network **calendar year deductible** applies separately to you and each of your covered dependents. After **covered benefits** reach the out-of-network **calendar year deductible**, the plan will begin to pay benefits for **covered benefits** for **out-of-network services and supplies** for the rest of the **calendar year**. **Covered benefits** applied to the network **calendar year deductible** will not be applied to satisfy this out-of-network **calendar year deductible**.

Family Calendar Year Deductible
This is the amount of **covered benefits** that you and your covered dependents incur each **calendar year** for which no benefits will be paid. After **covered benefits** reach this family calendar year deductible, this Plan will begin to pay benefits for **covered benefits** that you and your covered dependents incur for the rest of the calendar year.

Family Network Calendar Year Deductible
This is the amount of **network covered benefits** that you and your covered dependents incur each **calendar year** for which no benefits will be paid. After **covered benefits** reach this family **network calendar year** deductible, this Plan will begin to pay benefits for **covered benefits** that you and your covered dependents incur for the rest of the **calendar year**. **Covered benefits** applied to the out-of-network **calendar year deductible** will not be applied to satisfy this network **calendar year deductible**.

Family Out-of-Network Calendar Year Deductible
This is the amount of **out-of-network covered benefits** that you and your covered dependents incur each **calendar year** for which no benefits will be paid. After **covered benefits** reach this family **out-of-network calendar year** deductible, this Plan will begin to pay benefits for **covered benefits** that you and your covered dependents incur for the rest of the **calendar year**. **Covered benefits** applied to the network **calendar year deductible** will not be applied to satisfy this out-of-network **calendar year deductible**.

Prescription Drug Calendar Year Deductible
This is the amount of **covered benefits** for **prescription drugs** that you must incur in a **calendar year** before **prescription drug** benefits are paid. After **covered benefits** reach the **prescription drug calendar year deductible,** the plan will begin to pay benefits for **covered benefits** for **prescription drug** for the rest of the **calendar year**.

Prescription Drug Network Calendar Year Deductible
This is the amount of **covered benefits** for **network prescription drugs** that you must incur in a **calendar year** before **prescription drug** benefits are paid. The **network prescription drug calendar year deductible** applies separately to you and each of your covered dependents. After **covered benefits** reach the **prescription drug calendar year deductible,** the plan will begin to pay benefits for **covered benefits** for **network prescription drugs** for the rest of the **calendar year**. **Covered benefits** applied to the **out-of-network prescription drug calendar year deductible** will not be applied to satisfy this **network prescription drug calendar year deductible**.

Prescription Drug Out-of-Network Calendar Year Deductible
This is the amount of **covered benefits** for **out-of-network prescription drugs** that you must incur in a **calendar year** before **prescription drug** benefits are paid. The **out-of-network prescription drug calendar year deductible** applies separately to you and each of your covered dependents. After **covered benefits** reach the **prescription drug calendar year deductible,** the plan will begin to pay benefits for **covered benefits** for **out-of-network prescription drugs** for the rest of the **calendar year**. **Covered benefits** applied to the **network prescription drug calendar year deductible** will not be applied to satisfy this **out-of-network prescription drug calendar year deductible**.

Copayments and Benefit Deductible Provisions

Copayment, Copay
This is a specified dollar amount or percentage of the **negotiated charge** required to be paid by you at the time you receive a covered service from a **network provider**. It represents a portion of the applicable expense. When **Aetna** compensates **out-of-network providers** on the basis of the **recognized charge**, the plan **coinsurance** is based on this charge.

Per Admission Copayment and Deductible
A per admission **copayment** or **deductible** is an amount you are required to pay when you or a covered dependent have a **stay** in an inpatient facility. It represents a portion of the applicable expense.

Separate **copayments** and **deductibles** may apply per facility. These **copayments** and **deductibles** are in addition to any other **copayments** and **deductibles** applicable under this plan. They apply to each **stay** as an inpatient in a facility. If you are in the same type of facility more than once, and your **stay** is separated by less than 10 days (regardless of cause), only one per admission **copayment** or **deductible** will apply.

Hospital Emergency Room Copayment and Deductible
A separate **hospital** emergency room **copayment** or **deductible** applies to each visit for emergency care by a covered person in a **hospital's** emergency room. This **copayment** or **deductible** applies unless the covered person is admitted to the **hospital** as an inpatient within 24 hours after a visit to a **hospital** emergency room.

These **copayments** and **deductibles** are in addition to any other **copayments** and **deductibles** applicable under this plan.

Covered benefits applied to the **hospital** emergency room **copayment** or **deductible** cannot be applied to any other **copayment** or **deductible** required in your plan. Likewise, **covered benefits** applied to your plan's other **copayments** or **deductibles** cannot be applied to meet the **hospital** emergency room **copayment** or **deductible**.

Coinsurance Provisions

Coinsurance
This is the percentage of your **covered benefits** that the plan pays and the percentage of **covered benefits** that you pay. The percentage that the plan pays is referred to as the "**Plan Coinsurance**". Once applicable **deductibles** have been met, your plan will pay a percentage of the **covered benefits**, and you will be responsible for the rest of the costs. The **coinsurance** percentage may vary by the type of expense.

Network Maximum Out-of-Pocket Limits
Covered benefits that are subject to the **maximum out-of-pocket limits** include those charges incurred for medical, dental, vision, and **prescription drug** benefits.

The **maximum out-of-pocket limit** is the maximum amount you are responsible to pay for network **covered benefits** during the calendar year. This Plan has an individual and family **maximum out-of-pocket limit**. As to the individual **maximum out-of-pocket** limit, each of you must meet your **maximum out-of-pocket limit** separately and they cannot be combined and applied towards one limit. **Covered benefits** applied to the **out-of-network maximum out-of-pocket limit** will not be applied to satisfy this **network maximum out of pocket limit**.

Individual
Once the amount of eligible expenses for **network services and supplies** you or your covered dependents have paid during the calendar year meets the individual **maximum out-of-pocket limit**, this Plan will pay 100% of **covered benefits** for **network services and supplies** that apply toward the limit for the remainder of the calendar year for that person.

Family
Once the amount of eligible expenses for **network services and supplies** you or your covered dependents have paid during the calendar year meets this family **maximum out-of-pocket limit**, this Plan will pay 100% of **covered benefits** for **network services and supplies** that apply toward the limit for the remainder of the calendar year for all covered family members.

Out-of-Network Maximum Out-of-Pocket Limits
Covered benefits that are subject to the **maximum out-of-pocket limits** include those charges incurred for medical, dental, vision, and **prescription drug** benefits.

The **maximum out-of-pocket limit** is the maximum amount you are responsible to pay for out-of-network **covered benefits** during the calendar year. This Plan has an individual and family **maximum out-of-pocket limit**. As to the individual **maximum out-of-pocket** limit, each of you must meet your **maximum out-of-pocket limit** separately and they cannot be combined and applied towards one limit. **Covered benefits** applied to the **network maximum out-of-pocket limit** will not be applied to satisfy this **out-of-network maximum out of pocket limit**.

Individual
Once the amount of eligible expenses for **out-of-network services and supplies** you or your covered dependents have paid during the calendar year meets the individual **maximum out-of-pocket limit**, this Plan will pay 100% of **covered benefits** for **out-of-network services and supplies** that apply toward the limit for the remainder of the calendar year for that person.

Family
Once the amount of eligible expenses for **out-of-network services and supplies** you or your covered dependents, have paid during the calendar year meets this family **maximum out-of-pocket** limit, this Plan will pay 100% of **covered benefits** for **out-of-network services and supplies** that apply toward the limit for the remainder of the calendar year for all covered family members.

Semi-Private Room Rate

The **room and board** charge that an institution applies to the most beds in its semi-private rooms with 2 or more beds. If there are no such rooms, **Aetna** will figure the rate based on the rate most commonly charged by similar institutions in the same geographic area.

Adjustment Rule

If, for any reason, a covered person is entitled to a different amount of coverage, coverage will be adjusted as of its effective date.

Benefits for claims incurred after the date the adjustment becomes effective are payable in accordance with the revised Policy provisions. In other words, there are no vested rights to benefits based upon provisions of this Policy in effect prior to the date of any adjustment.

Any increase in the level of benefit because of a change in the amounts shown in this *Schedule of Benefits* will not provide additional benefits for **covered benefits** incurred before the change took effect.

General

This *Schedule of Benefits* replaces any similar *Schedule of Benefits* previously in effect under your plan of benefits. Requests for coverage other than that to which you are entitled in accordance with this *Schedule of Benefits* cannot be accepted. Coverage is underwritten by Aetna Life Insurance Company.

The insurance described in this *Schedule of Benefits* will be provided under Aetna Life Insurance Company's Policy form GR-96812-Costco, and this schedule is part of your Policy.

Keep This Schedule of Benefits With Your Policy.